UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

CARL G. SIMPSON, ET AL.	:	
	:	Case No. C-1-000014
Plaintiffs,	:	
v.	:	Judge Dlott
	:	
INTERMET CORPORATION, ET AL.	:	DECLARATION OF DOUG HOWELL
	:	
Defendants.	:	

Doug Howell truthfully states the following is based on his personal knowledge and further truthfully states that he is competent to testify if called.

1. I am the Human Resources Manager at Intermet Corporation.

2. Intermet was a self-insured employer under the Ohio Workers' Compensation Act. Intermet was in full compliance with Ohio's Workers Compensation Act at the time of Carl Simpson's death.

3. Intermet's managers periodically conducted lockout and other safety audits to make sure that lockout and other safety procedures were being followed.

4. Carl D. Simpson received lockout training shortly after beginning employment. Attached as Exhibit 1, is a copy of Simpson's certification that he had received this training. This document was maintained by Intermet in the ordinary course of its business in Simpson's personnel file.

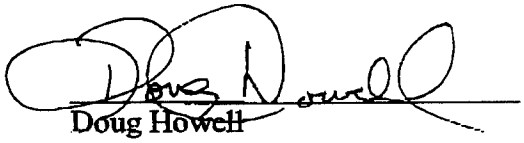
5. Simpson also received machine specific lockout training on the Sutter machine, which was part of the Dry Sand Molding Certification.

6. Attached as Exhibit 2 is a copy of Simpson's beneficiary designation for Internet's Savings and Individual Retirement Plan, in which Simpson certified that he was not married. This document was maintained by Internet in the ordinary course of its business in Simpson's personnel file.

7. Attached as Exhibit 3 is Simpson's application for life insurance offered by Internet, in which he lists Bonnie Reed as his friend. This document was maintained by Internet in the ordinary course of its business in Simpson's personnel file.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on May 3, 2004.



Doug Howell

INTERMET

IRONTON IRON, INC.
2520 South Third Street
P.O. Box 98
Ironton, Ohio 45638-0098
(614) 532-0009
Telecopier: (614) 532-4534

I have received training in the following OSHA required topics:

Hazard Communication
Silica Dust
Lock Out
MSDS
Hearing Conservation
Electrical Safety

Carl D. Simpson
Name

3/12/93
Date

July 16-17, 1992
Date of Training

EXHIBIT
1
PENGAD-Bayonne, N. J.

ENROLLMENTFORM

Intermet Corporation Savings and Individual Retirement Plan for Hourly Employees
Ironton Iron, Inc.

Employee Information

[redacted] [redacted] 10/31/1213
SOCIAL SECURITY NUMBER DATE OF BIRTH HIRE DATE

Simpson CARL D
LAST NAME FIRST NAME M.I.

3916 CO RD 614 Willow Wood Ohio ☒ SINGLE ☐ MARRIED
STREET ADDRESS APT. # MARITAL STATUS

Willow Wood OH 45696
CITY STATE ZIP

Employee Contribution (circle the desired percentage)

☒ I elect the following percentage of my pay to be designated as a **pre-tax savings** contribution to the Plan.

1% (2%) 3% 4% 5% 6% 7% 8% 9% 10% 11% 12% 13% 14% 15%

TOTAL CONTRIBUTION MAY NOT EXCEED 15% OF PRE-TAX SALARY.

Employee Investment Elections (must be in 5% increments)

FOR FUTURE INVESTMENTS ONLY, CURRENT BALANCES WILL NOT BE AFFECTED.

FUND NAME	*PERCENTAGE*
NBD Stable Asset Income Fund	%
George Putnam Fund of Boston	%
Putnam Fund for Growth and Income	%
Putnam Vista Fund	50 %
Putnam New Opportunities Fund	50 %
Putnam International Growth Fund	%
TOTAL◇	100%

Employee Signature (below by the "X")

☒ I have received the appropriate Fund Prospectus for the investment options in my plan and I hereby authorize the investment elections and reductions in my gross earnings and/or payroll deductions as noted above.

☐ I do not wish to contribute to the Plan at this time.

X Carl D Simpson 3/24/97
DATE

Employer Signature

X / / DATE

EXHIBIT 2
PENGAD-Bayonne, N. J.

All enrollment forms must be returned by **Monday March 31, 1997.** Plan assets for participants whose forms are received after Monday March 31, 1997 will default to the NBD Stable Asset Income Fund.

☑ INITIAL DESIGNATION
☐ CHANGE OF DESIGNATION

Beneficiary Designation

To Be Retained in employer's files

PARTICIPANT INFORMATION

SOCIAL SECURITY NUMBER [redacted]

LAST NAME	FIRST NAME	M.I.
SIMPSON	CARL	D

STATEMENT OF SPOUSES RIGHTS

I understand that if I am married and have not designated my spouse as the primary beneficiary of the amounts due under the Plan upon my death, this form will not be valid unless my spouse has consented by signing the Spousal Consent to Alternative Beneficiary section below and by having his or her signature witnessed by a Plan representative or a notary public. I also understand that if I am not married at this time, but I later marry before receiving the full amount of my benefits, my spouse will automatically become the Primary Beneficiary of the amounts due upon my death unless he or she consents to the designation of an Alternate Beneficiary in accordance with the procedures described in this paragraph.

DESIGNATION OF BENEFICIARY(IES)

If I die prior to or after the commencement of benefits, I designate the following to be my Primary Beneficiary(ies) to receive any amounts due or remaining under the Plan.

NAME	RELATIONSHIP	ADDRESS	DATE OF BIRTH	SHARE OF PROCEEDS (AS %)
Bonnie Reed	Friend	3976 CR 64 Willow Wood O 45696	[redacted]	100%
				TOTAL 100%

If none of the Primary Beneficiaries are living on the date of my death, I hereby designate the following to be my Contingent Beneficiary(ies) to receive any amounts due or remaining under the Plan.

NAME	RELATIONSHIP	ADDRESS	DATE OF BIRTH	SHARE OF PROCEEDS (AS %)
Jeremy Simpson	Son	Same	[redacted]	100%
				TOTAL 100%

Unless otherwise provided above, payment will be made in equal shares to such of the Primary Beneficiaries who survive me, or if none, to such of the Contingent Beneficiaries who survive me. If no Beneficiary survives me, payment will be made in accordance with the terms of the Plan.

UNMARRIED PARTICIPANT'S CERTIFICATION

☒ I have checked here if I am not married and I so certify to the Plan Administrator. I hereby agree to notify the Plan Administrator immediately, should I become married. I understand that upon my marriage before benefits begin, if I fail to complete a new Beneficiary Designation form my spouse will automatically become the Primary Beneficiary.

PARTICIPANT SIGNATURE

I make the Designation of Beneficiary specified above and revoke any previous Designation made under the Plan. I understand that the Beneficiaries' names may be revoked at any time by filing a new Designation in writing with my Employer. I understand that this form will be used in conjunction with the Distribution Request Form which has withholding on it.

DATE	SIGNATURE OF PARTICIPANT	SIGNATURE OF WITNESS
	Carl D. Simpson	James H. Kelly

SPOUSAL CONSENT TO ALTERNATIVE BENEFICIARY(IES)

I certify that I am the spouse of the employee who has made the Designation shown on this form. I have voluntarily consented to permit my spouse to name a Beneficiary *other* than myself to receive the death benefits due under the Plan.
I acknowledge that I understand that: (1) the effect of my consent will be to forfeit benefits I would otherwise be entitled to receive upon my spouse's death; (2) my spouse's Designation of an Alternative Beneficiary is not valid unless I consent to it; and (3) my consent is irrevocable unless my spouse revokes this Designation or unless provided otherwise under a qualified domestic relations order.

DATE	SPOUSE'S SIGNATURE	WITNESSED BY PLAN REPRESENTATIVE

OR WITNESSED BY NOTARY PUBLIC	SUBSCRIBED AND SWORE TO ME ON	MY COMMISSION EXPIRES
	/ /	/ /

IMPORTANT: This form should be completed by all Participants in the Plan. It will govern the payment of benefits when death occurs before the distribution of the Participant's Account has commenced. In addition, this form will also govern the payment of benefits when death occurs after an installment distribution has commenced if a Participant has not completed a new Form; however, a Participant should complete a new form when this alternative form of payment is elected. This form is to be kept within the employer's files.

MEDICAL MUTUAL OF OHIO

APPLICATION AND POLICY CHANGE

(PLEASE USE BALL POINT PEN)

FAXED 8/4/98

ENROLLEE: ☐ POLICY CHANGE ☒ NEW ENROLLEE ☐ COBRA APPLICATION

GROUP NO.: LEVEL OF BENEFITS ☒ Single ☐ Two Person ☐ Family ☐ Medicare Supplement EMPLOYMENT STATUS ☒ Active ☐ Retired ☐ COBRA

EMPLOYEE CLOCK NUMBER: EMPLOYEE DEPT. NO.: PAYROLL LOCATION:

CHANGES: ☐ Add Dependents due to: ☐ Marriage ☐ Birth ☐ Adoption ☐ Drop Dependents Due To: ☐ Divorce ☐ Death ☐ Other ☐ New Name ☐ New Address ☐ Change to Medicare Elig. ☐ Change Coverage ☐ Other

DATE OF EVENT MO. DAY YR. 04 20 98 COV. OR CHANGE EFF. DATE MO. DAY YR. 04 20 98

BASIC INFORMATION

Last Name Simpson First Name Carl M. Initial D Phone No.

Street Address 3990 C.R. 1? City Willow Wood State OH Zip 45696

Employee Date of Birth MO. DAY YR. [redacted] Sex ☒ M ☐ F Employee Social Security Number [redacted] Marital Status ☒ Single ☐ Married ☐ Widowed ☐ Divorced Date Married MO. DAY YR.

Employer Company Name Ironton Iron Date of Hire Full Time MO. 3 DAY 12 YR. 73 Job Title Casting Processor

Check Coverage Desired: ☐ Health ☐ Drug ☐ Dental ☐ Vision ☐ Life

MEDICARE INFORMATION

Are you covered by Medicare? ☐ YES ☐ NO If YES, Medicare No. Effective Date: ☐ Hemodialysis

Is your spouse covered by Medicare? ☐ YES ☐ NO If YES, Medicare No. Effective Date: ☐ Hemodialysis

OTHER INSURANCE INFORMATION

Do you or any of your family members have other health/dental insurance? ☐ YES ☐ NO ☐ ACTIVE ☐ RETIRED

(This includes coverage with this, or any other Medical Mutual Plan) Names of Insured:

If YES, employed by:

Name of other Insurance carrier: Policy No. ☐ Single ☐ Family

Address ☐ No Coverage

What date did your most recent health insurance program become effective (check box if no prior/current coverage)? / /

What date did/will this most recent health insurance program terminate? / /

DEPENDENT INFORMATION

RELATIONSHIP	BIRTHDATE MO. DAY YR.	SEX	LAST NAME (if different)	FIRST NAME	SOC. SEC. NO.	OVER AGE DEPENDENT STATUS
Spouse		☐ M ☐ F				
☒ Child ☐ Adopted ☐ Stepchild ☐ Other*	[redacted]	☒ M ☐ F	"	Jeremy		☒ Full-Time Student ☐ Disabled Medicare Elig.: ☐ Hemodialysis ☐ Disability
☒ Child ☐ Adopted ☐ Stepchild ☐ Other*		☐ M ☒ F		Angel		☒ Full-Time Student ☐ Disabled Medicare Elig.: ☐ Hemodialysis ☐ Disability
☐ Child ☐ Adopted ☐ Stepchild ☐ Other*	/ /	☐ M ☐ F				☐ Full-Time Student ☐ Disabled Medicare Elig.: ☐ Hemodialysis ☐ Disability
☐ Child ☐ Adopted ☐ Stepchild ☐ Other*	/ /	☐ M ☐ F				☐ Full-Time Student ☐ Disabled Medicare Elig.: ☐ Hemodialysis ☐ Disability
☐ Child ☐ Adopted ☐ Stepchild ☐ Other*	/ /	☐ M ☐ F				☐ Full-Time Student ☐ Disabled Medicare Elig.: ☐ Hemodialysis ☐ Disability
☐ Child ☐ Adopted ☐ Stepchild ☐ Other*	/ /	☐ M ☐ F				

*Legal Documentation (court decree, guardianship papers, etc.) must be attached to this application if relationship is marked other.

LIFE

GROUP NUMBER DIV. CLASS SALARY $ ☐ Hourly ☐ Weekly ☐ Monthly ☐ Annually

DEPENDENT LIFE (Complete only if you have eligible dependents) ☐ YES ☐ NO NOTE: A health questionnaire may be required if you choose dependent life at a later date.

SUPPLEMENTAL LIFE ☐ YES ☐ NO SUPP. LIFE AMOUNT $ MLI USE ONLY EFF. DATE / /

Complete only if Employer offers Dependent Life Ins. Complete only if Employer offers Supplemental Life Ins.

OTHER INSURANCE / AMOUNT

BENEFICIARY LAST NAME	FIRST NAME	DATE OF BIRTH	RELATIONSHIP	BENEFIT*
1. Reed	Bonnie	[redacted]	friend	100 %
2.				%
3.		MO. DAY YR.		%

*Unless otherwise noted, if two or more beneficiaries are named, the proceeds shall be paid in equal shares to the named beneficiaries surviving the insured.

SIGNATURE

I hereby apply to Medical Mutual of Ohio and Medical Life Insurance Company (MMO and MLI) for the coverage indicated above. I authorize my employer/organization to deduct from my pay and remit any required contribution for the cost of said coverage. I authorize any medical professional, hospital, clinic, or other medical or medically related facility, government agency, or other person to provide to MMO/MLI information including copies of records concerning advice, care or treatment provided to me and/or my dependents including, without limitation, information relating to mental illness or use of drugs or alcohol. I understand that the kind of coverage for which I am making application contains coordination of benefits, workers' compensation, and subrogation provisions and acknowledge MMO/MLI's right to enforce these provisions. I have read the above statements and represent that the information provided is true and complete to the best of my knowledge. I understand that the provision of any false information on this application may result in the termination of my benefits and may subject me to legal action by MMO/MLI. I understand I must notify MMO within 30 days of occurrence of any changes in status. I understand that if I am not actively at work on the date my coverage would otherwise become effective, my insurance will not begin until the day I return to work.

Applicant's Signature Date

WAIVER

I hereby waive coverage under the health insurance program ☐ ☐ FOR MYSELF AND FAMILY MEMBERS ☐ FOR MYSELF

I hereby waive coverage under the Life Insurance program ☐ ☐ FOR FAMILY MEMBERS ONLY ☐ FOR ONLY THE FOLLOWING:

I understand that if I decide to enroll or add family members at a later date, I will be required to complete a medical history questionnaire and meet certain medical underwriting requirements before coverage will be offered. I further understand that if I and/or my eligible family members are accepted for enrollment at some future date, I am subject to the pre-existing condition restrictions specified in the contract.

Signature Carl D. Simpson Date 4-20-98

WARNING: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. (Ohio Revised Code Section 3999.21)

Z1860 R4/97 APP 94003 DISTRIBUTION: WHITE-MMO GREEN & CANARY-MedLife PINK-Marketing GOLD-Group

EXHIBIT 3

PENGAD-Bayonne, N. J.